b. Naturopathic services; and (5-15-84)

c. Bio-feedback therapy; and (11-10-87)

d. Fertility related services including testing. (11-10-87)

02. Procedure Excluded. The costs of physician and hospital services for the following types of treatments are excluded from MA payment. This includes both the procedure itself, and the costs for all follow up medical treatment directly associated with such a procedure: (6-1-86)

a. Elective medical and surgical treatment, except for family planning services, without Departmental approval. Procedures that are generally accepted by the medical community and are medically necessary may not require prior approval and may be eligible for payment; or (6-1-86)

b. Cosmetic surgery which is not medically necessary and is accomplished without prior approval of the MA Section of the Department; or (5-15-84)

c. Gastric stapling procedures; or (6-1-86)

d. Panniculectomy procedures; or (6-1-86)

e. Acupuncture; or (6-1-86)

f. Bio-feedback therapy; or (6-1-86)

g. Intestinal bypass surgery for the treatment of morbid obesity; or (6-1-86)

h. Laetrile therapy; or (6-1-86)

i. Organ transplants; lung, pancreas, or other transplants considered investigative or experimental procedures and multiple organ transplants; or (10-1-91)

j. Procedures and testing for the inducement of fertility. This includes, but is not limited to, artificial inseminations, consultations, counseling, office exams, tuboplasties, and vasovasostomics. (11-10-87)

k. New procedures of unproven value and established procedures of questionable current usefulness as identified by the Public Health Service and which are excluded by the Medicare program are excluded from MA payment; or (5-15-84)

l. All medical procedures for the treatment of obesity; or (6-1-86)

m. Drugs supplied to patients for self-administration other than those allowed under the conditions of Section 126.; or (12-31-91)

n. Examinations: (6-1-86)

i. For routine checkups, other than those associated with the EPSDT program; or (6-1-86)

ii. In connection with the attendance, participation, enrollment, or accomplishment of a program; or (6-1-86)

iii. For employment; or (6-1-86)

o. Services provided by psychologists and social workers who are employees or contract agents of a physician, or a physician's group practice association except for psychological testing on the order of the physician; or (6-1-86)

p. The treatment of complications, consequences or repair of any medical procedure, in which the original procedure was excluded from MA coverage, unless the resultant condition is life threatening as determined by the MA Section of the Department; or (5-15-84)

q. Medical transportation costs incurred for travel to medical facilities for the purpose of receiving a noncovered medical service are excluded from MA payment. (5-15-84)

r. Eye exercise therapy. (10-25-88)

s. Surgical procedures on the cornea for myopia. (3-2-94)

066. -- 069. (RESERVED).

070. PHYSICIAN SERVICES. (7-1-93)

01. Services Provided. The Department will reimburse for treatment of medical and surgical conditions by doctors of medicine or osteopathy subject to the limitations of practice imposed by state law, and to the restrictions and exclusions of coverage contained in Sections 065. and Subsection 070.02. All services not specifically included in this chapter are excluded from reimbursement. (12-31-91)

02. Restriction of Coverage. (7-1-93)

a. Out-patient psychiatric mental health services are limited to twelve (12) hours of psychiatric evaluations per eligible recipient in any twelve (12) month period; and any combination of individual or group psychotherapy services provided by a physician up to a maximum of forty-five (45) hours of service in the consecutive twelve (12) months period beginning with the first such service. (11-10-81)

b. Particular restrictions pertaining to payment for sterilization procedures are contained in Section 090.; and (12-31-91)

c. Restrictions governing payment for abortions are contained in Section 095.; and (12-31-91)

d. Payment for tonometry is limited to one (1) examination for individuals over the age of forty (40) years during any twelve (12) month period (in addition to tonometry as a component of examination to determine visual acuity). In the event examination to determine visual acuity is not done, two (2) tonometry examinations per twelve (12) month period are allowed recipients over the age of forty (40). This limitation does not apply to recipients receiving continuing treatment for glaucoma. (10-25-88)

e. Payment for physical therapy services performed in the physician's office is limited to those services which are described and supported by the diagnosis; and (11-10-81)

f. Payment for allowable injectable vitamins will be allowed when supported by the diagnosis. Injectable vitamin therapy is limited to Vitamin B12 (and analogues), Vitamin K (and analogues), folic acid, and mixtures consisting of Vitamin B12, folic acid, and iron salts in any combination. (11-10-81)

g. Corneal transplants and kidney transplants are covered by the MA program. (5-15-84)

03. Mispresentation of Services. Any representation that a service provided by a nurse practitioner, nurse midwife, physical therapist, physician assistant, psychologist, social worker, or other nonphysician professional as a physician service is prohibited. (6-1-86)

04. Physician Penalties for Late PRO Review. Medicaid will assess the physician a penalty for failure to have a preadmission review in accordance with Subsection 080.02.a. and Idaho Department of Health and Welfare Rules and Regulations, Title 3, Chapter 10, "Rules Governing Provider Reimbursement in Idaho," as amended. A penalty will be assessed according to Subsection 070.05. entitled "Physician Penalty Chart." The assessed penalty will be based on the total Medicaid allowed amount for the physician services for the entire stay after any third party payment has occurred. (3-1-92)

05. Physician Penalty Chart.

a. A request for preadmission PRO review that is one (1) day late will result in a penalty. Medicaid will deduct from the total Medicaid paid amount of the related claim the lesser of five percent (5%) or fifty dollars ($50). (3-1-92)

b. A request for preadmission PRO review that is two (2) days late will result in a penalty. Medicaid will deduct from the total Medicaid paid amount of the related claim the lesser of ten percent (10%) or one hundred dollars ($100). (3-1-92)

c. A request for preadmission PRO review that is three (3) days late will result in a penalty. Medicaid will deduct from the total Medicaid paid amount of the related claim the lesser of fifteen percent (15%) or one hundred and fifty dollars ($150). (3-1-92)

d. A request for preadmission PRO review that is four (4) days late will result in a penalty. Medicaid will deduct from the total Medicaid paid amount of the related claim the lesser of twenty percent (20%) or two hundred dollars ($200). (3-1-92)

e. A request for preadmission PRO review that is five (5) days late or later will result in a penalty. Medicaid will deduct from the total Medicaid paid amount of the related claim the lesser of twenty-five percent (25%) or two hundred and fifty dollars ($250). (3-1-92)

06. Physician Excluded from the Penalty. Any physician who provides care but has no control over the admission, continued stay or discharge of the patient will not be penalized. Assistant surgeons and multi-surgeons are not excluded from the penalty. (3-1-92)

07. Procedures for Medicare Cross-over Claims. If a MA recipient is eligible for Medicare, the physician must bill Medicare first for the services rendered to the recipient. (11-10-81)

a. If a physician accepts a Medicare assignment, the payment for the Medicare co-insurance and deductible will be made and forwarded to the physician automatically based upon the EOMB information on the computer tape which is received from the Medicare Part B Carrier on a weekly basis. (11-10-81)

b. If a physician does not accept a Medicare assignment, a Medicare EOMB must be attached to the appropriate claim form and submitted to the Bureau for the billing of Medicare co-insurance and deductible. (11-10-81)

c. In order for the Department to make payment, the physician must agree to accept the payment from Medicare and Medicaid as payment in full for covered services. (11-10-81)

071. PAYMENT FOR MEDICAL PROCEDURES PROVIDED BY NURSE PRACTITIONERS, NURSE MIDWIVES, AND PHYSICIAN ASSISTANTS. The Medicaid Program will pay for services provided by nurse practitioners (NP), nurse midwives (NM), and physician assistants (PA), as defined in Subsections 003.29., 003.30., and 003.35. and under the following provisions: (12-31-91)

01. Identification of Services. The required services shall be covered under the legal scope of practice as identified by the appropriate State rules of the NP, NM, or PA. (11-10-81)

02. Deliverance of Services. The services shall be delivered under physician supervision as required by each program. (11-10-81)

03. Billing of Services. Billing for the services shall be as provided by the NP, NM, or PA, and not represented as a physician service. (11-10-81)

04. Reimbursement Limits. The Department shall establish reimbursement limits for each service to be delivered by the NP, NM, or PA. Such services shall be reimbursed as either the billed charge or reimbursement limit established by the Department, whichever is less. (11-10-81)

072. -- 074. (RESERVED).

075. PODIATRY. The Department will reimburse podiatrists for treatment of acute foot conditions. Acute foot conditions, for the purpose of this provision, means any condition that hinders normal function, threatens the individual, or complicates any disease. Preventive foot care may be provided if vascular restrictions or other systemic disease is threatened. (11-10-81)

076. -- 079. (RESERVED).

080. IN-PATIENT HOSPITAL SERVICES. (7-1-93)

01. Exceptions and Limitations. The following exceptions and limitations apply to in-patient hospital services: (11-10-81)

a. Payment is limited to semi-private room accommodations. (11-10-81)

i. The Department must not authorize reimbursement for any part of a private room unless the attending physician orders a private room for the patient because of medical necessity. (11-10-81)

ii. If a patient or the family of a patient desires a private room, the party ordering the private room will be responsible for full payment for the private room. (11-10-81)

b. If a MA recipient is eligible for Medicare, the hospital must first bill Medicare for the services rendered to the recipient. (11-10-81)

c. If services are related to the professional component of laboratory and x-ray services, the payment for Medicare co-insurance and deductible will be made and forwarded to the hospital automatically based upon the EOMB cross-over information. (11-10-81)

d. Hospital care associated with noncovered services as contained in Section 065. is excluded from MA payment. (12-31-91)

02. Payment Procedures. The following procedures are applicable to in-patient hospitals: (11-10-81)

a. The patient's admission and length of stay is subject to preadmission, concurrent and retrospective review by a Peer Review Organization (PRO) designated by the Department. PRO review will be governed by provisions of the PRO Provider Manual as amended. If such review identifies that an admission or continued stay is not medically necessary, then no Medicaid payment will be made. Failure to obtain a timely PRO review as required by Section 080., and as outlined in the PRO Provider Manual as amended, will result in the PRO conducting a late review. After a PRO review has determined that the hospital stay was medically necessary, Medicaid will assess a late review

penalty to the hospital as outlined in Subsection 080.04. entitled "Hospital Penalty Chart." (3-1-92)

i. The hospital must submit claims for care and services provided to the MA recipient on the appropriate claim forms and attach the PRO approval certification for those diagnoses where preadmission approval is required as well as PRO approval certification for any hospital stay with a length of stay which exceeds the 75th percentile for the primary diagnosis (according to Western Regional P.A.S. Length of Stay published by Health Knowledge System). (12-3-90)

ii. Reimbursement for services originally identified as not medically necessary by the PRO will be made if such decision is reversed by the appeals process required in Idaho Department of Health and Welfare Rules and Regulations Title 5, Chapter 3, Subsection 301., et seq., "Rules Governing Contested Cases and Declaratory Rulings." (12-31-91)

iii. Absent the Medicaid recipient's informed decision to incur services deemed unnecessary by the PRO, or not authorized by the PRO due to the negligence of the provider, no payment for denied services may be obtained from the recipient. (12-3-90)

b. In reimbursing licensed hospitals, the Department will pay the lesser of customary charges or the reasonable cost of semi-private rates for in-patient hospital care in accordance with the rules and regulations set forth in Idaho Department of Health and Welfare Rules and Regulations, Title 3, Chapter 10, "Rules Governing Medicaid Provider Reimbursement in Idaho."The upper limits for payment must not exceed the payment which would be determined as reasonable cost using the Title XVIII standards and principles. (12-31-91)

c. If a MA recipient is eligible for Medicare the hospital must first bill Medicare for the services rendered to the recipient. (11-10-81)

i. If services are related to the professional component of laboratory and x-ray services, the payment for Medicare co-insurance and deductible will be made and forwarded to the hospital automatically based upon the EOMB cross-over information. (11-10-81)

ii. For all other services, a Medicare EOMB must be attached to the appropriate claim form and submitted to the Bureau for the billing of Medicare co-insurance and deductible charges. (11-10-81)

d. Diagnostic tests and procedures, including laboratory tests, pathological, and x-ray examinations whether provided on an in-patient or an out-patient basis, are reimbursable only if related to the diagnosis and treatment of a covered medical condition. (12-3-90)

e. Only tests or evaluations specifically ordered by a physician will be reimbursed. (12-3-90)

03. Duties of the Designated PRO. The designated PRO shall prepare, distribute and maintain a provider manual. The PRO provider manual shall be distributed by the PRO and periodically updated thereafter. The manual will include, and is not limited to, the following: (10-1-89)

a. The PRO's policies, criteria, standards, operating procedures, and forms for performing: preadmission monitoring, assessment reviews, continued stay requests, and requests for retroactive medical reviews. (10-1-89)

b. Department selected diagnoses and elective procedures in which a hospital will request preauthorization of an admission, transfer, or continuing stay. (10-1-89)

c. A provision that the PRO will mail the hospital a completed certification statement within five (5) days of an approved admission, transfer, or continuing stay. (10-1-89)

d. The method of notice to hospitals of PRO denials for specific admissions, transfers, continuing stays, or services rendered in post-payment reviews. (10-1-89)

e. The procedures which providers or recipients will use to obtain reconsideration of a denial by the PRO prior to appeal to the Department in accordance with the provisions of Idaho Department of Health and Welfare Rules and Regulations Title 5, Chapter 3, Section 301., et seq., "Rules Governing Contested Cases and Declaratory Rulings." Such requests for reconsideration by the PRO must be made in writing to the PRO within sixty (60) days of the issuance of the "Notice of Non-Certification of Hospital Days." (12-31-91)

04. Hospital Penalty Chart.

a. A request for a preadmission and/or continued stay PRO review that is one (1) day late will result in a penalty of two hundred and sixty dollars ($260), from the total Medicaid paid amount of the inpatient hospital stay after any third party payment. (3-1-92)

b. A request for a preadmission and/or continued stay PRO review that is two (2) days late will result in a penalty of five hundred and twenty dollars ($520), from the total Medicaid paid amount of the inpatient hospital stay after any third party payment. (3-1-92)

c. A request for a preadmission and/or continued stay PRO review that is three (3) days late will result in a penalty of seven hundred and eighty dollars ($780), from the total Medicaid paid amount of the inpatient hospital stay after any third party payment. (3-1-92)

d. A request for a preadmission and/or continued stay PRO review that is four (4) days late will result in a penalty of one thousand and forty dollars ($1,040), from the total Medicaid paid amount of the inpatient hospital stay after any third party payment. (3-1-92)

e. A request for a preadmission and/or continued stay PRO review that is five (5) days late or greater will result in a penalty of one thousand three hundred dollars ($1,300), from the total Medicaid paid amount of the inpatient hospital stay after any third party payment. (3-1-92)

081. ORGAN TRANSPLANTS. The Department may purchase organ transplant services for bone marrows, kidneys, hearts, and livers when provided by hospitals approved by the Department. The Department may purchase cornea transplants for conditions where such transplants have demonstrated efficacy. (10-1-91)

01. Heart or Liver Transplants. Heart or liver transplant surgery will be covered only if the procedure is performed in a transplant facility approved for transplant of the heart or liver by the Health Care Financing Administration for the Medicare program and has completed a provider agreement with the Department. (10-1-91)

02. Kidney Transplants. Kidney transplantation surgery will be covered only in a renal transplantation facility participating in the Medicare program after meeting the criteria specified in 42 CFR 405 Subpart U. Facilities performing kidney transplants must belong to one (1) of the End Stage Renal Dialysis (ESRD) network area's organizations designated by the Secretary of Health and Human Services for Medicare certification. (10-1-91)

03. Living Kidney Donor Costs. The transplant costs for actual or potential living kidney donors are fully covered by Medicaid and include all reasonable preparatory, operation, and post operation recovery expenses asso-

ciated with the donation. Payments for post operation expenses of a donor will be limited to the period of actual recovery. (10-1-91)

04. Coverage Limitations. When the need for transplant of a second organ such as a heart, lung, liver, bone marrow, pancreas, or kidney represents the coexistence of significant disease, the organ tranplants will not be covered. (10-1-91)

a. Each kidney or lung is considered a single organ for transplant; (10-1-91)

b. Retransplants will be covered only if the original transplant was performed for a covered condition and if the retransplant is performed in a Medicare/Medicaid approved facility; (10-1-91)

c. A liver transplant from a live donor is considered an investigative procedure and will not be covered; (10-1-91)

d. Multi-organ transplants such as heart/lung or kidney/pancreas and the transplant of artificial hearts or ventricular assist devices are not covered; (10-1-91)

e. Except for cornea transplants, all organ transplants are excluded from MA payment unless preauthorized by the PRO and performed for the treatment of medical conditions where such transplants have a demonstrated efficacy. (10-1-91)

05. Noncovered Transplants. Services, supplies, or equipment directly related to a noncovered transplant will be the responsibility of the recipient. (10-1-91)

06. Follow Up Care. Follow up care to a recipient who received a covered organ transplant may be provided by a Medicare/Medicaid participating hospital not approved for organ transplantation. (10-1-91)

082. -- 084. (RESERVED).

085. OUT-PATIENT HOSPITAL SERVICES. On site services eligible for payment include preventive, diagnostic, therapeutic, rehabilitative or palliative items, or services furnished by or under the direction of a physician or dentist, unless excluded by any other provisions of this chapter. (3-22-93)

01. Exceptions and Limitations. (7-1-93)

a. Claims for emergency room service must include a diagnosis and copy of the emergency room record. (11-10-81)

b. Payment for emergency room service is limited to six (6) visits per calendar year. (11-10-81)

c. Emergency room services which are followed immediately by admission to inpatient status will be excluded from the six (6) visit limit. (11-10-81)

02. Procedures for Medicare Cross-over Claims.

a. If an MA recipient is eligible for Medicare, the hospital must first bill Medicare for the services rendered to the recipient. (11-10-81)

b. If the services are related to the professional component of laboratory and x-ray services, the payment for Medicare co-insurance and deductible will be made and forwarded to the hospital automatically based upon the EOMB cross-over information. (11-10-81)

c. For all other services, a Medicare EOMB must be attached to the appropriate claim form and submitted to the Bureau for the billing of Medicare co-insurance and deductible charges. (11-10-81)

086. -- 089. (RESERVED).

090. FAMILY PLANNING. Family planning includes counseling and medical services prescribed or performed by an independent licensed physician, or a qualified certified nurse practitioner or physician's assistant. Specific items covered are diagnosis, treatment, contraceptive supplies, related counseling, and restricted sterilization. (11-10-81)

01. Contraceptive Supplies. (7-1-93)

a. Contraceptive supplies include condoms, foams, creams and jellies, prescription diaphragms, intrauterine devices, or oral contraceptives. (11-10-81)

b. Contraceptives requiring a prescription are payable subject to Section 126. (12-31-91)

c. Payment for oral contraceptives is limited to purchase of a three (3) month supply. (11-10-81)

d. Payment to providers of family planning services for contraceptive supplies is limited to estimated acquisition cost. (11-10-81)

02. Sterilization Procedures -- General Restrictions. The following restrictions govern payment for sterilization procedures for eligible persons. (11-10-81)

a. No sterilization procedures will be paid on behalf of a recipient who is not at least twenty-one (21) years of age at the time he or she signs the informed consent. (11-10-81)

b. No sterilization procedures will be paid on behalf of any recipient who is twenty-one (21) years of age or over and who is incapable of giving informed consent. (11-10-81)

c. Each recipient must voluntarily sign the properly completed "Consent Form", HW 0034, in the presence of the person obtaining consent (see Subsection 090.03. for requirements). (12-31-91)

d. Each recipient must sign the "Consent Form" at least thirty (30) days but not more than one hundred eighty (180) days, prior to the sterilization procedures (see Subsection 090.04. for exceptions). (12-31-91)

e. The person obtaining consent must sign the "Consent Form", HW 0034, and certify that he or she has fulfilled specific requirements in obtaining the recipient's consent (see Subsection 090.03. for requirements). (12-31-91)

f. The physician who performs the sterilization must sign the "Consent Form", HW 0034, certifying that the requirements of Subsection 090.03. have been fulfilled. (12-31-91)

g. No sterilizations for individuals institutionalized in correctional facilities, mental hospitals, or other rehabilitative facilities are eligible for payment unless such sterilizations are ordered by a court of law. (11-10-81)

h. Hysterectomies performed solely for sterilization purposes are not eligible for payment (see Subsection 090.06. for those conditions under which a hysterectomy can be eligible for payment). (12-31-91)

i. All requirements of state or local law for obtaining consent, except for spousal consent, must be followed. (11-10-81)

j. Suitable arrangements must be made to insure that information as specified in Subsection 090.02. is effectively communicated to any individual to be sterilized who is blind, deaf, or otherwise handicapped. (12-31-91)

03. Sterilization Consent Form Requirements. Informed consent exists when a properly completed "Consent Form", HW 0034, is submitted to the Department together with the physician's claim for the sterilization. (11-10-81)

a. The consent form must be signed and dated by: (1-16-80)

i. The MA recipient to be sterilized; and (1-16-80)

ii. The interpreter, if one (1) is provided; and (1-16-80)

iii. The individual who obtains the consent; and (11-10-81)

iv. The physician who will perform the sterilization procedure. (11-10-81)

v. If the individual obtaining the consent and the physician who will perform the sterilization procedure are the same person, that person must sign both statements on the consent form. (11-10-81)

b. Informed consent must not be obtained while the recipient in question is: (11-10-81)

i. In labor or childbirth; or (1-16-80)

ii. Seeking to obtain or obtaining an abortion; or (1-16-80)

iii. Under the influence of alcohol or other substances that affect the individual's state of awareness. (1-16-80)

c. An interpreter must be provided if the recipient does not understand the language used on the consent form or the language used by the person obtaining the consent. (11-10-81)

d. The person obtaining consent must:

i. Offer to answer any questions the recipient may have concerning the procedure; and (11-10-81)

ii. Orally advise the recipient that he/she is free to withhold or withdraw consent to the procedure at any time before the sterilization without affecting his/her right to future care or treatment, and without loss or withdrawal of any federally funded program benefits to which the individual might otherwise be entitled; and (11-10-81)

iii. Provide a description of available alternative methods of family planning and birth control; and (1-16-80)

iv. Orally advise the patient that the sterilization procedure is considered to be irreversible; and (11-10-81)

v. Provide a thorough explanation of the specific sterilization procedure to be performed; and (11-10-81)

vi. Provide a full description of the discomfort and risks that may accompany and follow the performing of the procedure, including an explanation of the type and possible effects of any anesthetic to be used; and (11-10-81)

vii. Provide a full description of the benefits or advantages that can be expected as a result of the sterilization; and (11-10-81)

viii. Advise that the sterilization procedure will not be performed for at least thirty (30) days except under extreme circumstances as specified in Subsection 090.04. (12-31-91)

e. The person securing the consent from the recipient must certify by signing the "Consent Form" that: (11-10-81)

i. Before the recipient signed the consent form, he or she was advised that no federal benefits would be withheld because of the decision to be or not to be sterilized; and (11-10-81)

ii. The requirements for informed consent as set forth on the consent form were orally explained; and (11-10-81)

iii. To the best of his knowledge and belief, the patient appeared mentally competent and knowingly and voluntarily consented to the sterilization. (11-10-81)

f. The physician performing the sterilization must certify by signing the "Consent Form" that: (11-10-81)

i. At least thirty (30) days have passed between the recipient's signature on that form and the date the sterilization was performed; and (11-10-81)

ii. To the best of the physician's knowledge the recipient is at least twenty-one (21) years of age; and (11-10-81)

iii. Before the performance of the sterilization the physician advised the recipient that no federal benefits will be withdrawn because of the decision to be or not to be sterilized; and (11-10-81)

iv. The physician explained orally the requirement for informed consent as set forth in the "Consent Form"; and (11-10-81)

v. To the best of his knowledge and belief the recipient to be sterilized appeared mentally competent and knowingly and voluntarily consented to the sterilization. (11-10-81)

g. If an interpreter is provided, he must certify by signing the "Consent Form" that: (11-10-81)

i. He accurately translated the information and advice presented orally to the recipient; and (11-10-81)

ii. He read the "Consent Form" and accurately explained its contents; and (11-10-81)

iii. To the best of his knowledge and belief, the recipient understood the interpreter. (11-10-81)

.04. Exceptions to Sterilization Time Requirements. If premature delivery occurs or emergency abdominal surgery is required, the physician must certify that the sterilization was performed because of the premature delivery or emergency abdominal surgery less than thirty (30) days, but no less than seventy-two (72) hours after the date of the recipient's signature on the consent form; and (11-10-81)

a. In the case of premature delivery, the physician must also state the expected date of delivery and describe the emergency in detail; and (11-10-81)